

FILED

under the Due Process Clause. *Reck v. Pate*, 367 U.S. 433, 440 (1961); see also *State v. Mills*, 562 N.W.2d 276, 283 (Minn. 1997). Coercive police activity is a necessary predicate

February 15, 2024

Filed in District Court
State of Minnesota
1/10/2024 10:32 AM

**OFFICE OF
APPEALS**

to a finding that a statement was involuntary. *Colorado v. Connelly*, 479 U.S. 157, 167 (1986). If, after a *Miranda* warning, a defendant waives his rights to silence and to counsel, the State must show by preponderance of the evidence that the statement was voluntary and not coerced. *State v. Camacho*, 561 N.W.2d 160, 170 (Minn. 1997). Once again, the court examines several factors under a totality of the circumstances framework to determine whether Defendant's statements were made voluntarily or were the result of coercive police action.

2. In the second prong of the Defendant's argument, he claims that his statements were not voluntarily due to his upbringing in Vietnam, witnessing police atrocities in Vietnam, his education, and the hold upon his person, among other factors. The Court finds this argument to be weakened by Defendant's own willingness and actions during the interview with Det. McLain and his testimony at a hearing on November 17, 2023.

Defendant claims that his upbringing in Vietnam and his witnessing of police practices in Vietnam shaped his view of police officers so significantly that he was overwhelmed and intimidated by the mere presence of Det. McLain. Relevant testimony offers a different perspective. Det. McLain testified that he told Defendant multiple times throughout the interview that Defendant could decline to speak with him or could tell him to leave. Det. McLain further testified about the efforts to provide Defendant with an interpreter to ensure an accurate recording of Defendant's statements. Det. McLain was not hostile, did not wear his official uniform, and spoke with a measured and sympathetic tone. These are not the actions of a malicious actor overwhelming the will of the Defendant

rendering the statements involuntary. See *State v. Riley*, 568 N.W.2d 518, 525 (Minn. 1997); and, *State v. Mills*, 562 N.W.2d 276, 283 (Minn. 1997). Furthermore, the Defendant's upbringing in Vietnam holds relatively little weight in these proceedings considering Defendant has been in the United States for approximately twenty years, owns a business, a home, and is able to drive. This indicates that Defendant is well acclimated to the customs of the United States and is able to live here with relative ease.

Defendant next points to his education limiting his ability to understand his constitutional rights. This factor is offset by Defendant's own comprehension of Det. McLain during the interview and willingness to engage with the detective. Once again, Det. McLain told Defendant he did not have to speak with him and could tell the detective to leave if he so wished. Defendant did not take the option to do so and willingly spoke with the detective. Defendant claims his limited education is a heavy factor in finding his statements involuntary, but this Court disagrees. Defendant displayed understanding both during the interview and on the witness stand. Defendant answered questions competently, demonstrating no erroneous statements, delusions, or non-linear thinking. A police officer is not obligated to assess the intellectual capacity of every defendant he comes across. Defendant is a functional adult, living ably in society; and, for these reasons, this Court finds Defendant's limited education not sufficient enough to find his statements were made involuntarily.

Lastly, Defendant argues that because he was under a 72-hour hold, his statements to Det. McLain were not the product of rational intellect and free will. This is simply not true. The 72-hour hold was in response to the car accident and the subsequent risk of suicidal harm, both of which bear little relevance to Det. McLain's interview and the

allegations against Defendant. Defendant further alluded to his mind being addled by
sedative medicine, stating many times that he was dizzy and tired during the interview.
However, Det. McLain testified that Defendant was alert and awake during their
conversation. Defendant would begin answering questions before Det. McLain finished
asking the question showing a very capable understanding of the conversation and not the
result of fatigued mind. In addition, Dr. Ward testified that Defendant was dismissive of
his team, demonstrating that Defendant had the capability to refuse to speak with
individuals.

In conclusion, this Court is not persuaded that Defendant's will was overborne and
his statements were not the product of a rational mind and free will. Defendant was able to
answer his own attorney's questions with little difficulty but displayed a curious lack of
memory when cross examined by the State's attorney. Defendant displayed a sufficient
understanding of what was happening around him and of the conversation he had with Det.
McLain, rendering his statements wholly and freely voluntary.

ORDER

1. Defendant's Motion to Suppress is hereby **DENIED**.

Dated: January 19, 2024

BY THE COURT:



Lennon, Carrie
2024.01.19
09:46:58 -06'00'

Caroline H. Lennon
Judge of District Court

Imaging (continued)

8 - Unknown

HCMC RADIOLOGY Unknown

Unknown

03/12/06 1431 - Present

Letters

Letter by Bloss, Gray Charles on 4/3/2022

Status: Open

Letter body:

STATE OF MINNESOTA

FIRST JUDICIAL DISTRICT

DISTRICT COURT

COUNTY OF SCOTT

PROBATE/MENTAL HEALTH DIVISION

In the Matter of the Civil Commitment of:

Michael T Huynh

DOB: 10/31/1970,

Respondent.

**PETITION FOR JUDICIAL
COMMITMENT**

D.C. File No.

C.A. File No.

Gray Bloss, LGSW, at Hennepin County Medical Center, is interested in the respondent as a Social Worker, and to the best of his/her knowledge, information, and belief, petitioner respectfully represents:

1. Respondent was born on 10/31/1970;
2. Respondent lives at 1560 Village Square Blvd
Shakopee MN 55379, and has residence in Scott County, Minnesota for the purpose of judicial commitment;

3. Respondent's spouse and nearest kindred are:

NAME
Kim Huynh

RELATIONSHIP
Spouse

ADDRESS
952-258-3238

4. The observations of respondent's behavior showing that respondent is Mentally Ill, and that there is no suitable alternative to involuntary commitment are set forth in Exhibit A and the Examiner's Statement attached.

5. ☒ An Examiner's Statement supporting respondent's commitment is attached.
☐ Petitioner is unable to procure an examiner's statement as described in Exhibit A.

WHEREFORE, Petitioner prays the Court commit the respondent, Michael T Huynh, to the Commissioner of Human Services, or other treatment facility according to law.

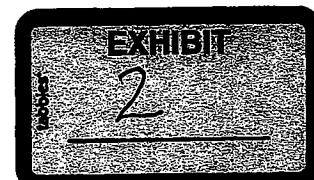
I declare under penalty of perjury under the laws of the state of Minnesota that the foregoing is true and correct.

Executed on this 4 day of April, 2022, in the county of Hennepin, in the state of Minnesota.

/s/ Gray Bloss
(Signature)

Name: Gray Bloss, LGSW

Address: Hennepin County Medical Center, 701 Park Avenue, Minneapolis, MN 55415



03/29/2022 - ED to Hosp Admission (Discharged) in HCMC - 255222

Letters (continued)

Phone: 612-873-3000

In the Matter of
Michael T Huynh

FILE NO.

The following observations of the patient's behavior provide a factual basis for believing the patient is, Mentally Ill, and in need of hospitalization.

Mr. Michael Huynh is a 51 year old Vietnamese-speaking male with a history of Mood Disorder who was brought to the ED on 03/29/2022 secondary to a motor vehicle accident in which he collided with a semi-truck while driving the wrong way within the setting of a suicide attempt.

The patient was received by Dr. Rischardson on 03/29/2022, "51 yo M who was driving on the wrong side of the road and head-on semi, unclear if restrained. Also has recent legal issues and concern that this is suicidal attempt. Initially was responsive and trying to choke himself and later became unresponsive. Intubated at St. Francis prior to arrival 2/2 non-responsiveness."

The patient was assessed on 04/01/2022 by Dr Ward, "Mr. Huynh denies SH/SI and would not elaborate on why he attempted suicide. He refused to engage during the discussion and provider team was unable to have an accurate suicide assessment. Given high lethality of attempt and refusal to engage, team has recommended pt be placed on 72 hr hold and psychiatry team will start commitment process... Mr. Huynh denies SH and when asked about SI he states "I don't know." When asked about his emotional state, he continually replies "not good today." He does endorse feeling better yesterday. He would not disclose the difference between yesterday and today. He does state he feels safe in hospital.

Attempted to speak w/ pt about his discussion w/ primary team about interaction w/ 15 y.o. boy. Pt would not speak about it. Told pt he did not have to talk about what happened w/ us if he did not want to. Informed pt our purpose was to help his mental health and emotional wellbeing. Pt calmly let Writer know he no longer wanted to talk. Informed pt Writer may stop by later.

Conversation w/ Wife:

Wife, Kim, has been very distraught about her husband. She relays her husband told her he was hearing a voice to kill himself and that he did not allow her to visit him today. She was very concerned about this. Informed wife, Michael's behavior is not atypical for someone w/ recent suicide attempt. Wife asked if there was anything that happened today to make Michael more upset. Did not inform wife about incident regarding 15 y.o. boy. Instead, spoke to wife about Michael being on 72 hr and commitment process. She agrees he needs to be hospitalized as she is worried he will try to hurt himself again. She is very worried about him. Through conversation she is very tearful.

Wife also mentions being unable to speak English and unable drive. She lives far away. She is able to get a ride to the hospital through Sunday 4/3, but will no longer have a ride after. She is struggling w/ what is happening and has two friends and sister, but is not so close w/ sister and friends are busy w/ their families. Asked pt if she would want to be informed of legal status and she would. Told wife would put note in chart to keep her updated."

In light of the gravity of the circumstances precipitating admission coupled with the extent to which his capacity to care for himself in a purposeful way is presently compromised, Hennepin Healthcare is of the position that Mr.

03/30/2022 - EP to Hennepin Hospital (3/30/2022) 11

Letters (continued)

Michael Huynh is in need of civil commitment at this time.

/s/ Gray Bloss 04/04/2022

Letter by Crow, Kelsey M, MS on 3/31/2022

Status: Open

Letter body:

STATE OF MINNESOTA
COUNTY OF HENNEPIN

DISTRICT COURT – ADULT SERVICES DIVISION
FOURTH JUDICIAL DISTRICT

EXAMINER'S STATEMENT IN SUPPORT
OF PETITION FOR COMMITMENT

In the Matter of:
Michael T Huynh

I am a licensed physician or licensed consulting psychologist, and I am knowledgeable, trained and practicing in the diagnosis and treatment of:
Mental Illness, Mental Retardation and Chemical Dependency

I have examined the above named person within the last fifteen days, on 3/31/2022, and the results of the examination are stated below:

Behavioral evidence to support commitment:

Mr. Huynh denies any current SH/SI or plan to kill himself. He denies having any past hx of SH/SI or prev suicide attempts. He describes over the last month feeling desperate about a stressor in his life saying, "I didn't feel I could get through it." When asked to elaborate, pt refused and said it was "personal" or "private." Multiple attempts to re-ask the question led to the same answer. Pt was very dismissive of current hospitalization and of suicide attempt. He feels he only needs to be physically healed so he "can work w/ his hands" and "go back to work." He stated he feels better, knows he has help and that "I can get through it." He does not believe he needs to have a psychiatric evaluation.

Diagnostic impression and conclusions: Suicide Attempts. Mood Disorder, Unspecified

Recommended treatment:

He refused to engage during the discussion and provider team was unable to have an accurate suicide assessment. Given high lethality of attempt and refusal to engage, team recommended in-patient psychiatry admission.

I am of the opinion that the above named person is in need of treatment and should be committed to a treatment facility.

03/30/2022 - ED to Hosp Admission (Discharge) in HCMC

Letters (continued)

Will this person need neuroleptic medications? NO

Does this person have sufficient awareness of their situation and an understanding of treatment with neuroleptics to make this decision for themselves? NO

Dated: 3/31/2022

Signature: /s/ _____ Dr. Randy Ward
Examiner's name: Dr. Randy Ward

Hennepin County Medical Center
701 Park Avenue
Minneapolis, MN 55404

END OF REPORT

Notes (group 4 of 4) (continued)

Electronically signed by Fosu, Kofi, MD at 3/29/2022 3:45 PM

Progress Notes by Kolstad, Gretchen, RT at 3/29/2022 1530

RESPIRATORY VENT NOTE

Vent Settings: Ventilation Mode: AC, VC (Vol Ctrl)
Inspiratory Volume (mL): 510 mL
Ventilator Rate: 12 breaths per minute
Oxygen Concentration (%): 25
PEEP (cmH₂O): 5 cm
- Inspiratory Time (sec): 0.92
Exhaled Min Volume (mL): 6.63 mL
Peak Press: 21 CM H₂O
Static Press: 19 CM H₂O
Mean Airway Pressure (cm H₂O): 9.5 cm H₂O
Compliance (mL/cm H₂O): 39 mL/cm H₂O

Weaning: No
Breath Sounds: clear
Secretions: thin, blood tinged, small
Treatments: ventilator care

Will continue to Monitor and provide support.

Kolstad, Gretchen, RT, 3/29/2022 3:30 PM

Electronically signed by Kolstad, Gretchen, RT at 3/29/2022 3:30 PM

Progress Notes by Anderson, Karna, MDIV at 3/29/2022 1255

Chaplain Stabilization Room Note

Michael T Huynh DOB: 10/31/1970 Sex: male MRN:

LOS: 0 days

Initial Description: Michael T Huynh BIBA from St Francis Hospital after MVC this morning. Apparently had some sort of cord around his neck

Patient and Family Context: Wife, Kim (952-258-3238) here along with her friend, Kay (651-492-8954) who has been very supportive and is helping out with English as Kim and Michael are Vietnamese speakers. Kim does seem to understand some English but Interpreter is needed for all medical information. Kay understands more English but again, Interpreter needed for medical information. There is Vietnamese in house interpreter here in house today 3/29 who is able to be called back as needed. Kim had not been provided with very much medical info before she arrived here and had not heard about some sort of cord found around Michael's neck so she was caught by surprise with that information. That seemed to affect her a lot as it was then that she became more tearful. I stayed for support, hospitality in ED and then escorted them to SICU and got them settled there. Hospitality and introduction/orientation to

03/29/2022 - ED to Hosp Admission (Discharged) in HCMC Program

Notes (group 4 of 4) (continued)

staff and unit before leaving them to be with Michael who is intubated and sedated. Kim will be staying with friends and will have someone with her that speaks good English to help out with communication from the hospital when she is not here. They are Buddhist and had no specific needs that way, but do appreciate support

Plan: Spiritual Care Team is available to support patient and family as needed via pager 336-0410.

Anderson, Karna, MDIV, 3/29/2022 12:55 PM

Pager: 336-0410

Electronically signed by Anderson, Karna, MDIV at 3/29/2022 1:10 PM

Consults by Krook, Jon C, MD at 3/29/2022 1240

Consult Orders

1. CONSULT TO INTENSIVIST [220720869] ordered by Fosu, Kofi, MD at 03/29/22 1547

SICU CONSULT G3

Michael T Huynh DOB: 10/31/1970 Sex: male MRN: [REDACTED]

Summary:
Michael T Huynh is a 51 y.o. male who initially presented to OSH after being involved in a MVA after travelling the wrong direction at highway speeds. Responders also found the patient with a telephone cord wrapped around his neck. On pan scan at OSH he was originally thought to have rib fractures on the left of ribs 4-7, but on final read he was determined to have no fractures. He arrived in the stab room as a transfer from OSH for myoclonic jerking and subsequently received long-acting paralytic. No clear seizure activity, thought to potentially have an anoxic brain injury prior to transfer. Intubated and sedated on propofol. Fast U/S negative in stab room. He is now brought up to the SICU.

Assessment and Plan:

Neuro:

Assessment: Sedated on propofol on arrival. The patient may have suffered an anoxic brain injury but had a reassuring neuro exam with purposeful movements, attempted self extubation, and largely negative imaging outside of the rib fractures. CTA of neck with no evidence of carotid artery dissection or intracranial aneurysm. OSH CT showed no intracranial abnormality. PTA takes meclazine 25mg TID prn for vertigo.

Plan:

- Q1H neuro check
- Tylenol 625mg Q4H
- Fentanyl
- Propofol gtt, wean as able
 - monitor CK/TG Q72H
- Obtain over read of OSH CT c spine films before d/c'ing c spine precautions

HEENT:

Assessment: OSH CT showed an age indeterminate left medial orbital wall and nasal bone fractures.

Plan:

- Consult to OMFS

03/29/2022 - ED to Hosp Admission (Discharged) to HCMC

Notes (group 4 of 4) (continued)

Cardiac:

Assessment: Decreased NiBP's on presentation to stab. No obvious evidence of bleeding. May be due to propofol. No elevated trop. PTA lisinopril 20mg daily and amlodipine 5mg daily. Lactate elevated to 3.0 on arrival.

Plan:

- Cardiac monitoring and frequent vitals
- Hold PTA antihypertensives at this time
- Volume resuscitation with crystalloid/colloid vs blood product as needed

Pulmonary:

Assessment: Intubated and mechanically ventilated, minimal settings (FiO2 25%, PEEP 5). Imaging showed aspiration consolidation medial bilateral lower lobes. No injuries to chest/abdomen on imaging.

Plan:

- Mechanical ventilation. Monitor saturation and blood gasses.
- PS
- Likely extubation today

Gastrointestinal/Nutrition:

Assessment: NPO. Incidental hepatic steatosis on imaging.

Plan:

- Continue NPO
- Place corpak if unable to be extubated.
- Bedside swallow study if extubated shortly

Electrolytes:

Assessment: Low potassium on arrival (2.4), repleted. Other electrolytes wnl.

Plan:

- Replete electrolytes. Recheck as needed.

Renal:

Assessment: Foley in place. Ketone and protein present on urinalysis but otherwise WNL. 1L LR bolus given on arrival. Started on NS at 125 ml/hr.

Plan:

- Monitor Cr and U/O. Maintain U/O with MIVFs.
- Foley protocol

Endocrine:

Assessment: At risk for stress-induced hyperglycemia.

Plan:

- Monitor FSBGs, supplementary insulin (sliding scale vs. infusion), if needed.

Hematologic:

Assessment: Hemoglobin 11.2. INR 1.2 and PTT 23.8 on arrival. Fibrinogen 167.

Plan:

- Follow Hgb and coags, transfuse as necessary.

Infectious Disease:

Assessment: Leukocytosis of 17 with elevated absolute neutrophil count - likely reactive/stress-induced demargination. Afebrile. No infectious process suspected

Plan:

- Monitor fever curves and WBC.

03/29/2022 ED to Hosp Admission (Discharged) to HCMC Surgery Center (Discharged)

Notes (group 4 of 4) (continued)

Prophylaxis:

Famotidine for GI prophylaxis while intubated, SCDs for DVT prophylaxis. Chemical prophylaxis contraindicated due to bleeding risk at this time.

CHIEF COMPLAINT: Polytrauma

HISTORY OF PRESENT ILLNESS: Michael T Huynh is a 51 y.o. male who initially presented to OSH after being involved in a MVA after travelling the wrong direction at highway speeds. The patient's car was reportedly struck by 3 cars. Responders also found the patient with a telephone cord wrapped around his neck. It is unclear if he was wearing a seatbelt and no airbags deployed. He responded to pain on the scene and was intubated and sedated. He arrived in the stab room as a transfer from OSH for myoclonic jerking for which he subsequent received long-term paralytic after this. No clear seizure activity, thought to potentially have any anoxic brain injury prior to transfer. Found to have fractures of ribs 4-7 on the left on OSH pan scan. Intubated and sedated on propofol. Received additional sedation for attempts at self extubation. Fast U/S negative. He was purposely moving all four extremities. His potassium was low on presentation and repleted. He is now brought up to the SICU.

PAST MEDICAL/SURGICAL HISTORY:

HTN

Additional information is unable to be obtained due to unresponsiveness/intubation.

CURRENT HEALTH STATUS

Medications:

Medications Prior to Admission

Medication	Sig	Dispense	Refill
• amLODIPine (NORVASC) 5 mg oral TABS	Take 5 mg by mouth daily.		
• lisinopril (PRINIVIL;ZESTRIL) 20 mg oral TABS	Take 20 mg by mouth daily.		
• meclizine (UNIVERT) 25 mg oral tablet	Take 25 mg by mouth 3 times daily as needed for Vertigo.		

Per Epic/Outside records. Additional information is unable to be obtained due to unresponsiveness/intubation.

Allergies and drug reactions:

No Known Drug Allergies

Per Epic/Outside records. Additional information is unable to be obtained due to unresponsiveness/intubation.

PSYCHOSOCIAL HISTORY

Unable to be obtained due to unresponsiveness/intubation.

FAMILY HISTORY:

Unable to be obtained due to unresponsiveness/intubation.

REVIEW OF SYSTEMS:

Unable to obtain due to intubation

03/29/2022 - ED to Hosp Admission (Discharged) in HCMC Surgery

Notes (group 4 of 4) (continued)

PHYSICAL EXAMINATION:

Vital Signs:

BP (l) 125/106 | Pulse 82 | Temp 36.8 °C (98.3 °F) (Rectal) | Resp 16 | Wt 66.7 kg (147 lb 0.8 oz) | SpO2 100%

Neuro: Sedated. Arousable with vigorous stimulation. Moving extremities spontaneously/purposefully.

Head, eyes, ears, nose, throat: Intubated orotracheally. Scattered facial abrasion.

Neck: C-collar in place.

Cardiovascular: Regular rate and rhythm

Chest: Breath sounds clear bilaterally. Symmetric chest rise

Abdomen: Soft, nondistended, no grimacing with palpation

Extremities: No gross deformities or edema

GU: Foley in place, urine is clear

Pulses: Intact in all four extremities

Skin: Normal, no breakdown

REVIEW OF LABORATORY, PATHOLOGY, AND RADIOLOGY DATA:

Lab Results

Component	Value	Date
WBC	17.11 (H)	03/29/2022
RBC	5.86	03/29/2022
HGB	11.2 (L)	03/29/2022
HCT	36.9 (L)	03/29/2022
PLT	360	03/29/2022

Lab Results

Component	Value	Date
NA	141	03/29/2022
K	2.4 (AA)	03/29/2022
CHLORIDE	111 (H)	03/29/2022
GLU	100	03/29/2022
CR	0.70	03/29/2022

Labs and imaging reviewed.

Ryan Hatch, MS4

I Kofi Fosu, MD, saw the patient with the medical student and performed, or re-performed, the physical exam and medical decision-making and have verified the accuracy of all the medical student documentation and edited as necessary.

Fosu, Kofi, MD, 3/29/2022 3:59 PM
General Surgery Resident, PGY-3
Pager: 527-3025

FACULTY NOTE

I saw and evaluated the patient 3/29/2022. I discussed with the resident and agree with the resident's findings and plan documented in the resident's note from above. Any revisions by me are documented.

03/29/2022 - ED to Hosp Admission (3/29/2022) in Room

Notes (group 4 of 4) (continued)

Jon C. Krook M.D., F.A.C.S.
Hennepin County Medical Center
Department of Surgery

Electronically signed by Krook, Jon C, MD at 3/30/2022 1:09 PM

Nursing Assessment by Anton, Melinda R, RN at 3/29/2022 1200

Head to Toe Assessment

Shift Summary

Shift Summary

Neurological/Cognitive

Assessment Within Defined Limits except for:

Level of Consciousness: Sedated

HEENT

HEENT

Cardiac

Assessment Within Defined Limits except for:

Cardiac Monitor - bedside telemetry

Lead Monitored: Lead II

ECG Rhythm: normal sinus rhythm

Respiratory

Assessment Within Defined Limits except for:

Respiratory Assessment:

Mechanical Device: Continuous; Ventilator

Cough: Present

Frequency: Intermittent

Type: Productive

Neurovascular

Assessment Within Defined Limits except for:

Gastrointestinal

Within Defined Limits

Genitourinary

Assessment Within Defined Limits except for:

Voiding: Urinary catheter in place

03/29/2022 - ED to Hosp Admission (Discharged) in HCMC

Notes (group 4 of 4) (continued)

Musculoskeletal

Assessment Within Defined Limits except for:

Integumentary

Assessment Within Defined Limits except for:

Skin Assessment

Color/Characteristics - bruised (ecchymotic)

Patient Lines/Drains/Airways Status

Active LDAs

Name	Placement date	Placement time	Site	Days
Peripheral IV 03/29/22 18 gauge	03/29/22	1047	—	less than 1
Right Antecubital				
Peripheral IV 03/29/22 18 gauge	03/29/22	1047	—	less than 1
Left Antecubital				
Endotracheal Tube: oral	03/29/22	—	—	less than 1
endotracheal tube 7.5				
Urinary Catheter	03/29/22	1049	—	less than 1

Psychosocial

Within Defined Limits

Electronically signed by Anton, Melinda R, RN at 3/29/2022 7:34 PM

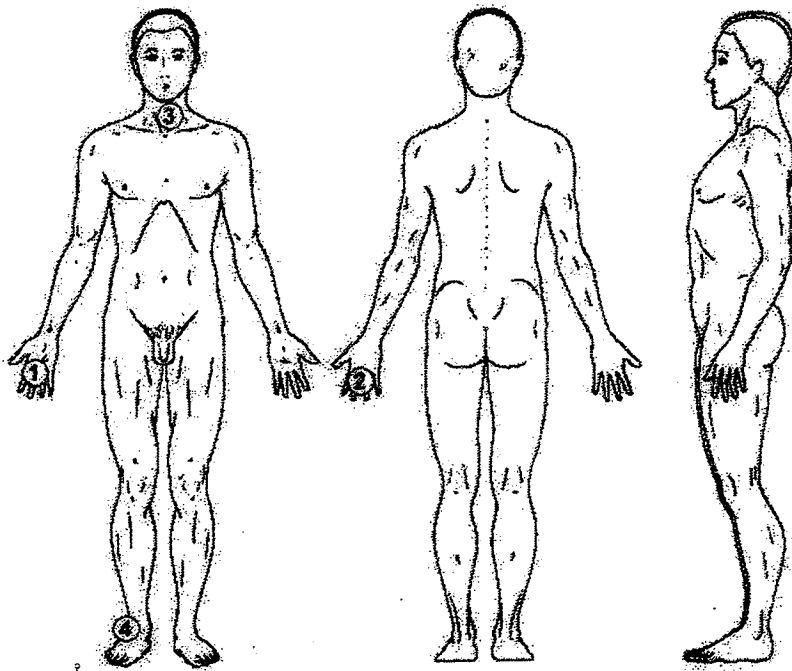
Progress Notes by Ahunkor, Chinonso E, RN at 3/29/2022 1130

Upon admission a Four Eyes Skin Inspection was completed with Mindee A. RN. Skin injuries were present. Will continue to use Braden Scale and skin bundle interventions as appropriate.

03/29/2022 - ED to Hosp Admission (Discharged) in HCMC Surgery Trauma Suite 2 (continued)

Notes (group 4 of 4) (continued)

Fig 1.1 Male figures, AP, PA, lateral, detail



- 1: Cuts and scratches
- 2: Abrasions
- 3: Abrasions across the neck
- 4: Cuts, scratches and abrasions

Electronically signed by Anunkor, Chinonso E, RN at 3/29/2022 12:05 PM

Progress Notes by Dawit, Nuhamin, RT at 3/29/2022 1047

Patient came in intubated from outside hospital with a 7.5 ETT. Initially came in at 22 at the teeth, advanced to 24. ETT verified by CXR and EtCO2. Patient placed on ventilator.

Electronically signed by Dawit, Nuhamin, RT at 3/29/2022 10:48 AM

ED Provider Notes

ED Notes by Zarzar, Rochelle A, MD at 3/29/2022 1701

ED Faculty Note

Michael T Huynh DOB: 10/31/1970 Sex: male MRN: 400000
Patient Arrival Date and Time: 3/29/2022 10:19 AM

03/29/2022 - ED to Hosp Admission (Discharged) to HCMC Surgery Service 2 (continued)

ED Provider Notes (continued)

FACULTY ATTESTATION

I, Rochelle Zarzar, MD, performed a history and physical examination of the patient and discussed management with the resident. I reviewed the resident's note and agree with the documented findings and plan of care as documented in the resident's note.

CRITICAL CARE

Upon my evaluation, this patient had a high probability of imminent life or limb-threatening deterioration due to MVC, which required my highest level of preparedness to intervene emergently, and I spent this critical care time directly and personally managing the patient.

I have personally provided 35 minutes of critical care time exclusive of time spent on separately billable procedures, treating other patients, or teaching time. Time includes obtaining history, reviewing medical records, examining the patient, ordering and review of studies, pharmacotherapy including sedation, pulse oximetry, review of laboratory data, interpretation of radiology studies, ECG interpretation, frequent reassessment, monitoring for potential decompensation, discussion with consultants and admission. This critical care time was performed to assess and manage the high probability of imminent deterioration that could result in death

Trauma Team: Tier 1 activation.

RN and ANCILLARY NOTES

I have reviewed nursing and ancillary notes, and agree with protocol as initiated.

PROCEDURES

Not applicable

MEDICAL DECISION MAKING

The current EKG reviewed and interpreted: , current labs reviewed and interpreted, current images reviewed and interpreted: , medical record discussed and medical record reviewed and interpreted

Please see the PMP note for full details of today's ED visit.

BP 116/76 (Cuff Location: Right Arm) | Pulse 88 | Temp 37.1 °C (98.8 °F) (Oral) | Resp 18 | Ht 1.676 m (5' 6") | Wt 66.7 kg (147 lb 0.8 oz) | SpO2 95% | BMI 23.73 kg/m²

Zarzar, Rochelle A, MD, 3/31/2022 5:01 PM

Electronically signed by Zarzar, Rochelle A, MD at 3/31/2022 5:02 PM

03/29/2022 ED to Hosp-Admission (Discharged) in HCMC Emergency Trauma Room 2 (Trauma)

ED Provider Notes (continued)

ED Notes by Kruger, Cheyanne M, RN at 3/29/2022 1106

Pt arrived to stab room as a transfer from an OSH. Pt was involved in an MVC at highway speeds. Pt was driving with a cord wrapped around his neck in a suicide attempt. Pt was intubated at the OSH and was transferred due to "seizure like activity". On arrival pt is intubated and on propofol. Pt moving all extremities and purposeful movement to ETT. Sedation increased. Small superficial abrasion to face and ligature marks under the c-collar. Pt to CT scan and report called to SICU RN.

Electronically signed by Kruger, Cheyanne M, RN at 3/29/2022 11:10 AM

ED Notes by Kruger, Cheyanne M, RN at 3/29/2022 1105

IV fentanyl bag discontinued on pt's arrival and destroyed with charge RN as witness

Electronically signed by Kruger, Cheyanne M, RN at 3/29/2022 11:06 AM

ED Stabilization Note by Overton-Harris, Petter, DO at 3/29/2022 1032

Emergency Medicine Stabilization Room Note

Michael T Huynh 10/31/1970

Sex: male MRN: 1111111

Patient Arrival Date and Time: 3/29/2022 10:19 AM

Emergency Medicine Faculty

Dr. Zarzar

EM Stabilization Resident

Overton-Harris, Petter, DO, 3/29/2022 12:49 PM

Stabilization Team

RN: Ian

HCA: Tenzin

Consultants trauma surgery

Pre-Hospital Events

Michael T Huynh is a 51 y.o. male presents to the stabilization room from outside hospital. The patient was reportedly found in his car following a highway speed MVC where he was driving against the flow of traffic and was found with a cord wrapped tightly around his neck with ligature marks. He presented to an outside hospital and subsequently intubated because he was unresponsive. There was a reported myoclonic jerking and he subsequently received long-term paralytic after this. No clear seizure activity, thought to potentially have any anoxic brain injury prior to transfer. Found to have ribs 4-7 fractures on the left at the outside hospital on CT pan scan.

Additional history is limited based on the patient's critical illness.

03/29/2022 ED to Hosp Admitted (Discharged) to HCMC

ED Provider Notes (continued)

Primary Survey

Airway: Intubated

Breathing: Mechanically ventilated

Circulation: Skin warm. Radial pulses.

Disability: GCS 3T (1- Does not open eyes; 1T - Makes no sounds, intubated; 1 - Makes no movements)

Exposure: Clothing removed.

Vital Signs

BP (I) 125/106 | Pulse 82 | Temp 36.8 °C (98.3 °F) (Rectal) | Resp 16 | Wt 66.7 kg (147 lb 0.8 oz) | SpO2 100%

Please see flowsheet for additional vitals.

Secondary Survey

General: Awake, Alert, Appropriate. C-collar in place

Head: NC/AT. No postauricular ecchymosis noted. Scattered abrasions to the face

Eyes: No conjunctival injection, Lids normal, no periorbital ecchymosis noted

ENT: No drainage noted from external ears or nares. No hemotympanum

Neck: Supple. Trachea midline. Ligature marks noted on the superior neck

Cardio: RRR. Appears well-perfused

Pulm: See primary survey

GI: Soft, NT/ND.

GU: Normal external genitalia. No blood noted from the meatus

MUSK: Freely moving all extremities. No contractures, deformities or cyanosis. No TTP or crepitance over large joints, chest wall, pelvis. No midline cervical, thoracic, or lumbar TTP or stepoffs palpated

Neuro: Patient intubated and sedated, however the patient had purposeful movements with reaching towards the ET tube with his left arm, spontaneous movements of bilateral lower extremities, interval mild movement of the right upper extremity

Skin: No rashes. Small scattered abrasions on the lower extremities. Skin warm/dry

Psych: Limited exam d/t acuity of patient's condition

Review of Systems

Review of systems and history limited by patient's acuity

Code Status

Team unaware of any advanced directive wishes of this patient prior to treatment of this patient.

Procedures

performed the following procedures:

Adult Trauma Resuscitation.

Michael T Huynh is a 51 y.o. male presenting with critical polytrauma, MVC, strangulation injury. As the patient arrived to the stabilization room, report was taken from medics. Patient transferred to STAB cart. Primary survey completed while patient placed on oximetry, cardiac monitoring, and cuff blood pressure monitoring. Trauma surgery paged. Intravenous access established and initial blood tests sent. Secondary survey completed

The patient was intubated and sedated on arrival, he began to purposely move his extremities with attempts at self extubation, he subsequently received additional sedation. This is an encouraging sign given the initial concern from report of hypoxic brain injury.

FAST U/S negative

CT pan scan from the outside hospital reviewed, consistent with rib fractures, otherwise negative, no CT angiography

- obtained, subsequently ordered in the emergency department
- CXR without acute abnormalities, ET tube high, repositioned
- Labs notable as below
- The patient may have suffered an anoxic brain injury but had a reassuring neuro exam with purposeful movements and largely negative imaging outside of the rib fractures.
- Plan to admit patient to surgical ICU to the trauma surgery service
- Report was called to the admitting team. Patient was transferred to their inpatient bed without complication.

03/29/2022 - ED to Hosp Admission (Pneumonia) (Pneumonia)

ED Provider Notes (continued)

Abs Monocyte 0.90

Abs Eosinophil 0.04

Abs Basophil 0.03

1249 **ED CHEMISTRY**

LABS(NA,K,CL,CO2,GLU,CREAT,CA-

IONIZED,ANION GAP)(I):

Sodium 141

Potassium 2.4(I)

Chloride 111(I)

AnGap 8

Glucose 100

ICA, Actual 3.44(I)

ICA pH Corrected 3.49(I)

Creatinine 0.70

BICARB 22

eGFR, High >120

eGFR, Low 109

Replaced K

1249 **BLOOD GASES(I):**

PH Ven 7.43(I)

PCO2 Ven 33(I)

PO2 Ven 35

Bicarb Ven 22(I)

O2 Sat Ven 64

Base Exc Ven -2.3

1249 **ED HEMOGLOBIN TOTAL (ED ONLY)(I):**

Hgb 9.9(I)

Sepsis Protocol: NA

Clinical Impression

1. Critical polytrauma

Disposition

Admit to trauma surgery for continued care, further neuro medication

Overton-Harris, Petter, DO, 3/29/2022 12:49 PM PGY-3

Emergency Medicine Resident

Electronically signed by Overton-Harris, Petter, DO at 3/29/2022 12:50 PM

ED Notes by Coombe-Bandt, Carelie M, RN at 3/29/2022 0854

Report received from St. Francis. Pt reportedly was struck by 3 cars on the hwy, Observed to be traveling the wrong way earlier. Responders found a telephone cord wrapped around his neck. Unknown if he was wearing a seatbelt. No airbags deployed. He responded to pain at the scene. He is intubated and currently has propofol at 30/hr and pentanyl at 25mcg/hr. Has received vecuronium x2. Has non displaced rib fractures. Foley and OGG also placed prior to transport

03/29/2022 - ED to Hosp Admission (Discharge)

ED Provider Notes (continued)

Electronically signed by Coombe-Bandt, Carelia at 3/29/2022 8:58 AM

H&P

H&P by Richardson, Chad J, MD at 3/29/2022 1026

TRAUMA SURGERY HISTORY AND PHYSICAL - PGY 1

Michael T Huynh DOB: 10/31/1970 Sex: male MRN: 400012

Patient Arrival Date and Time: 3/29/2022 10:19

History of Present Injury Event: 51 yo M who was driving on the wrong side of the road and head-on semi, unclear if restrained. Also has recent legal issues and concern that this is suicidal attempt. Initially was responsive and trying to choke himself and later became unresponsive. Intubated at St. Francis prior to arrival 2/2 non-responsiveness.

LOC: Yes - brief < 1 hr

INJURY CAUSE: Motor Vehicle Crash involving a(n) other vehicle semi that was hit Head-on. He was the driver and was not ejected. The vehicle was travelling at a speed of unknown mph.

Protective Devices: Unknown

Trauma Team Activated: Yes - Tier 1

Trauma Team Notified by:

Tier Level page received at 1022

Staff Surgeon: Chad Richardson

Pediatric Patient < 15 years: No.

Hennepin Trauma Team Time Out Completed: Yes

HISTORY

Past Medical History: Unable to obtain

Past Surgical History: Unable to obtain

Social History: Unable to obtain

Family History: Unable to obtain

Medications: Unable to obtain

Allergies: Unable to obtain

Patient accepts blood products: Unable to inquire of patient/family at this time

REVIEW OF SYSTEMS

Unable to obtain - intubated

PHYSICAL EXAM

Vital Signs: BP 125/91 | Pulse 85 | Temp 36.8 °C (98.3 °F) (Rectal) | Resp (l) 22 | Wt 66.7 kg (147 lb 0.8 oz) | SpO2 100%

Glasgow Coma Scale:

Motor 5=Localizes pain

4/15/2022 - Admission (Discharged) in HCMC Psychiatry O8 - 1

Admission Information

Admission Information

Arrival Date/Time:	Admit Date/Time:	04/05/2022 1749	IP Adm. Date/Time:	04/05/2022 1749
Admission Type:	Point of Origin:	Transfer From One Distinct Unit To Another Distinct Unit In Same Hospital	Admit Category:	
Means of Arrival:	Primary Service:	Psychiatry	Secondary Service:	N/A
Transfer Source:	Service Area:	HCMC-HFA SA	Unit:	HCMC Psychiatry O8 - 1
Admit Provider:	Heath, Ian J, MD	Attending Provider:	Heath, Ian J, MD	Referring Provider:
				Stahler, Paul A, MD

Discharge Information

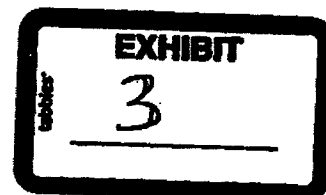
Date/Time: 04/15/2022 1457	Disposition: Discharged To Home Or Self Care (Routine Discharge)	Destination: Dsch - Home
Provider: Heath, Ian J, MD	Unit: HCMC Psychiatry O8 - 1	

Discharge Summary

Discharge Summary by Heath, Ian J, MD at 4/15/2022 1258

PSYCHIATRIC DISCHARGE SUMMARY - PGY 4

Michael T Huynh DOB: 10/31/1970 Sex: male MRN: **26522**



DATE OF ADMISSION: 4/5/2022

DATE OF DISCHARGE: 4/15/2022

DISPOSITION: Home

ATTENDING PSYCHIATRIST: Ian Heath, MD

OUTPATIENT PSYCHIATRIST: None. Follow-up planned with Scott County Mental Health and/or S1 walk-in clinic

PRIMARY CARE PROVIDER: Mark Westholder, MD through HealthPartners

ADMISSION DIAGNOSES

Major Depressive Episode, Single episode, with psychotic features

DISCHARGE DIAGNOSES

Major Depressive Episode, Single episode, with psychotic features

Pertinent medical diagnoses:

S/p MVA

HTN

Hyperlipidemia

SUMMARY OF HOSPITAL COURSE

Michael Huynh is a 51-year-old man, Vietnamese-speaking, who was transferred to inpatient psychiatry following inpatient medical hospitalization following suicide-attempt via driving his car against the flow of traffic resulting in MVC. While on inpatient medicine, patient was evaluated by psychiatry consult, patient exhibited signs/symptoms of major depressive disorder with psychotic features; he was found with a telephone cord wrapped around his neck with notable ligature marks with endorsement of suicidal ideation/intent; he initially requested discharge to home from medicine and was placed on 72-hour hold and petition for MI commitment placed; this was subsequently discontinued following patient providing voluntary consent to continue inpatient psychiatric treatment and mood stabilization.

04/05/2022 - Admission (Discharged) in HCMC Psychiatry DB - 1 (continued)

Discharge Summary (continued)

Although the patient was guarded, and informed of his right to remain silent, he informed that there was an allegation made against him pertaining to an alleged sexual interaction with a 15 yo male. A CPS report was made regarding patient's statement. No known legal proceedings related to the alleged incident occurred during his hospital admissions.

Upon inpatient psychiatry admission and evaluation, patient appeared subdued, with restricted affect, endorsed depressive ruminations and prior suicidal intent in his behaviors. He was experiencing auditory hallucinations at the time of admissions, these were challenging to clarify, but he stated that he heard voices and/or ego-dystonic urges that led to his suicidal behaviors. He exhibited sleep disturbance, both initial insomnia and early-morning awakening, reduced appetite, and psychomotor slowing, and anxious distress. The options of antidepressant and/or anxiety adjunct medication were discussed with patient as well as the option of ECT given the severity of depressive symptomatology.

Patient was initiated on antidepressant monotherapy with mirtazapine that was subsequently titrated over the course of his admission. He tolerated this medication well and appeared to have an early and robust response in both his mood and anxiety symptoms. He was also started on low-dose Ativan to address anxious distress and sleep disturbance in the setting of acute depressive episode with benefit. Patient had no history of prior substance-abuse was informed on risks of dependence and potential for abuse, though he was evaluated to be at low-risk for adverse effects.

Over the course of his admission, patient exhibited significant improvement in mood and anxiety symptoms. Sleep duration/quality, appetite disturbance, and psychomotor slowing showed great improvement within a few days of initiating medications. Auditory hallucinations/psychotic features resolved by day 5 of admission as did passive suicidal ideation. He became more active on the unit and social withdrawal/isolation symptoms gradually resolved. With further titration to mirtazapine 45 mg HS, patient also exhibited improvements in motivation, energy levels, and began demonstrating a significant shift toward future-orientation and hope/optimism in his thought content. He expressed future-goals including resuming work, working on his English skills, and increasing his engagement with family relationships. His affective range improved with noticeable brightening and ability to engage in humor. Subsequent regression in sleep benefit with the higher dosing of mirtazapine was addressed by a modest increase in nighttime lorazepam dosing, lorazepam was later switched to an as-needed basis given the global improvements in depression symptoms.

He had no behavioral issues during his admission. His family was highly supportive of patient and involved in his care, with frequent visits. Family expressed agreement with psychiatric management and concurred with assessment of patient's clinical improvements and readiness for discharge.

On the day of discharge, patient's thought process was organized and coherent and content was future-oriented without passive or active suicidal ideation. No HI, no AVH, paranoia, or other psychotic phenomena were present. He was advised on the risk/benefits of his current medications and both he and family were advised on plan to utilize lorazepam on an as-needed basis until anxious distress and residual insomnia remained improved. Instruction was given that patient avoid driving in the immediate, high-risk period following discharge until being seen for psychiatric follow-up and advised to avoid driving following use of benzodiazepine. Patient and family (niece) were advised on crisis services, APS, and HCMC walk-in clinic and primary plan for scheduled follow-up to be arranged with Scott County MH. Patient and family (niece), expressed understanding and agreement with the plan. He was discharged in stable, improved condition with a 30-day supply of all medications and plan for follow-up in place.

RECOMMENDATIONS AND FOLLOW-UP:

- 1.) Discharge to home
- 2.) Follow-up with outpatient psychiatry; to be arranged by Scott County Mental Health. HCMC Shapiro Walk-in clinic information also provided.

04/05/2022 - Admission (Discharged) in HCMC Psychiatry Q8 - 1 (continued)

Discharge Summary (continued)

- 1.) Medications per hospital regimen.
- 2.) Remain sober from alcohol and illicit substances
- 3.) Follow up with PCP in a couple of weeks or as needed

The next level of care provider has access to the EMR: Yes. Information sent also to Scott County MHC in advance of scheduled follow-up.

PENDING TEST RESULTS:

None

RECOMMENDATIONS OF ANY SUB-SPECIALTY CONSULTANTS:

Per Medicine Evaluation 4/5/22:

ASSESSMENT AND PLAN:

Aspiration consolidation medial bilateral lobes: resolved, seen on CT chest 3/29 at Allina, largely resolved by chest x-ray here later the same day. Lungs clear on exam
- monitor

Non-displaced left anterolateral rib fractures, 4-6, possibly 7: on CT scan at Allina, has tenderness to left anterolateral rib cage, no discoloration or bony prominences.
- monitor

- has pm oxycodone 5 mg q6h, consider taper soon
- continue Tylenol 975 TID for now

Age-indeterminate left medial orbital wall and nasal bone fractures: some bruising around right orbit, non-tender to palpation. Denies persistent visual blurring or eye pain.
- monitor

Possible pre-DM2: A1c 6.2 on admission, placed on insulin low s/scale on medicine, likely for trauma precaution, but had only 3 doses of 2 units each in 8 days on STN2.
- d/c insulin
- POC glucose checks daily for 5 days
- consider metformin

HTN: BP well-controlled so far.
- continue amlodipine 5 mg daily, lisinopril 20 mg daily

Hx hyperlipidemia:
- check panel

Smoking cessation: denies smoking

Palm, David A, APRN, CNP, 4/5/2022 5:52 PM

HOSPITAL PROBLEM LIST

Principal Problem:
Major depressive disorder, single episode, severe (**)
Active Problems:
Suicide attempt (**)
Resolved Problems:

04/05/2022 - Admission (Discharged) in HCMC Psychiatry 08 - 1 (continued)

Discharge Summary (continued)

* No resolved hospital problems. *

DISCHARGE VITALS:

BP 120/82 | Pulse 90 | Temp 36 °C (96.8 °F) (Tympanic) | Resp 14 | Wt 62.2 kg (137 lb 3.2 oz) | SpO2 98% | BMI 2.14 kg/m²

DISCHARGE MENTAL STATUS EXAMINATION:

Appearance: No apparent distress, Neatly groomed and Appears stated age and in good physical health
Behavior/relationship to examiner/demeanor: Cooperative, Engaged and Pleasant, appropriate eye contact
Speech rate: Normal
Speech volume: Normal
Speech articulation: Normal per interpreter
Speech coherence: Normal
Speech spontaneity: Normal
Thought Process (Associations): Logical/goal-directed
Thought process (Rate): Normal
Thought content: No suicidal ideation, No violent ideation and No homicidal ideation. No paranoia or delusional ideation. +Future-oriented content, hopefulness for the future. Improvement in depressive ruminations, guilt.
Abnormal Perception: None, resolved
Insight: Adequate, improved
Judgment: Adequate, improved
Sensorium: Alert, Oriented to person, Oriented to place, Oriented to date/time and Oriented to situation
Memory: Immediate recall intact, Short-term memory intact and Long-term memory intact
Attention/Concentration: Normal, adequate
Fund of Knowledge/Intelligence: Average
Mood (subjective report): "better," "good"
Affect (objective appearance): Appropriate/mood-congruent, improvement in range, brightens socially
Motor activity/EPS: Normal muscle strength and tone and Normal motor exam
Gait/Station: Normal
Language: Intact per interpreter

Interpreter Needed: yes- Vietnamese [43]

PLANNED DISCHARGE ORDERS:

Discharge Procedure Orders

Set up Med Minders and educate.

Order Comments: Set up Med Minders process and educate patient/caregivers.
Scheduling Specify what patient education is needed.
Instructions:

Why you were at the hospital:

Order Comments: You were in the hospital to have your mood stabilized and to have your depression treated.

Your legal status at discharge: No current

Major Tests/Treatments During This Encounter

Order Comments: Your care did not include major test or treatments, but followed an individualized treatment plan that included medication management, psychotherapy, and occupational therapy.

04/05/2022 - Admission (Discharged) in HCMC Psychiatry 08 1 (continued)

Discharge Summary (continued)

Studies Pending at Discharge

Order Comments: There were no pending lab tests or other tests at the time of your hospital discharge.

When should I be concerned?

Order Comments: Please call your Primary Care Provider, your clinic Psychiatrist, 911, or Acute Psychiatric Services (APS) at 612-673-3161. It is located on the 1st floor of the red building (717 South 7th Street) if:

- you have not slept for 2 or more nights in a row
- you have thoughts of self-harm
- you have thoughts of harming others
- you have increased depression
- you have feelings of helplessness or hopelessness
- you are unable to enjoy or complete usual activities

After discharge phone call:

Order Comments: - A nursing staff person will call you 2 to 3 days after you are discharged to see how you are doing.

Please keep the appointments that have already been made.

Order Comments: - Please keep the appointments that have already been made.

Please contact your primary care provider as needed.

Order Comments: Please contact your primary care provider as needed.

Ways to cope:

Order Comments:

- Take prescribed medicines as scheduled
- Keep follow-up appointments
- Talk to others about your concerns
- Get regular exercise
- Eat a healthy diet
- Use community resources
- Stay sober

Up as tolerated activity level.

Order Comments: UP AS TOLERATED

- Rest is an important part of healing. Save your energy by spreading out activities that make you tired. Rest as needed.
- Slowly increase your level of activity.

Resume Previous Activity

Order Comments:

- You may continue your usual level of activity. It is important to get regular activity!
- Rest is also an important part of healing. Save your energy by spreading out activities that make you tired.

Regular diet

Order Comments: - Eat a wide variety of foods, including fruits and vegetables, dairy, grains and meats.

Take your medicine and plan ahead for refills

Order Comments:

- It is important that you take the medicines on your list. Work with your health care provider or pharmacist if you have questions about your medicine.
- Plan ahead and use the Refill Line so that you don't run out of your medicine. It may take time to review your chart and get the medicine ordered.

Medication List

04/05/2022 - Admission (Discharged) in HCMC Psychiatry 06 - 1 (continued)

Discharge Summary (continued)

START taking these medications

Clonazepam 0.5 mg tablet

Commonly known as: ATIVAN

Take 1-2 tablets (0.5-1 mg) by mouth twice daily as needed for Anxiety (Insomnia).

Melatonin 5 mg Tabs

Take 1 tablet (5 mg) by mouth at bedtime.

Mirtazapine 45 mg Tabs

Commonly known as: REMERON

Take 1 tablet (45 mg) by mouth at bedtime.

Polyethylene glycol 3350 17 gm/scoop powder

Commonly known as: MIRALAX/GLUCOLAX

Take 1 capful to "17 gm" mark mixed with full glass of water twice every day as directed.

Replaces: polyethylene glycol 3350 17 g Packet

Simvastatin 20 mg Tabs

Commonly known as: ZOCOR

Take 1 tablet (20 mg) by mouth at bedtime.

CHANGE how you take these medications

Sennexon-S 8.6-50 mg tablet

Generic drug: sennosides-docusate sodium

Take 2 tablets by mouth twice daily as needed for Constipation.

What changed:

- when to take this
- reasons to take this

CONTINUE taking these medications

Amlodipine 5 mg Tabs

Commonly known as: NORVASC

Take 1 tablet (5 mg) by mouth daily.

Lisinopril 20 mg Tabs

Commonly known as: PRINIVIL; ZESTRIL

Take 1 tablet (20 mg) by mouth daily.

Meclizine 25 mg tablet

Commonly known as: UNIVERT

STOP taking these medications

04/05/2022 - Admission (Discharged) in HCMC Psychiatry OB - 1 (continued)

Discharge Summary (continued)

enoxaparin 30 mg/0.3 mL Solution
Commonly known as: LOVENOX

Insulin ASPART 100 units/mL FlexPen
Commonly known as: NovoLOG

HydroxyCODONE 5 mg tablet
Commonly known as: ROXICODONE

Polyethylene glycol 3350 17 g Packet
Commonly known as: MIRALAX/GLYCOLAX
Replaced by:

ASK your doctor about these medications

Acetaminophen 325 mg tablet
Take 3 tablets (975 mg) by mouth 3 times daily.

Where to Get Your Medications

**These medications were sent to HCMC Discharge 701 Park Avenue Red Building, Lower
Pharmacy - Red LL Level, Minneapolis MN 55415**

Hours: 24/7

Phone: 612-873-8586

- amlodipine 5 mg Tabs
- lisinopril 20 mg Tabs
- lorazepam 0.5 mg tablet
- melatonin 5 mg Tabs
- mirtazapine 45 mg Tabs
- polyethylene glycol 3350 17 gm/scoop powder
- Senexon-S 8.6-50 mg tablet
- simvastatin 20 mg Tabs

REVIEW OF ANTIPSYCHOTIC MEDICATIONS:

This patient was not discharged on multiple antipsychotic medications

LEGAL STATUS AT TIME OF DISCHARGE:

Voluntary

Susan Strand, MD
Psychiatry PGY-4
Telmediq Pager: 612-400-7124

DISCHARGE FACULTY NOTE

On 4/15/2022, I personally participated in the final examination and review of hospitalization and concur with the

Page 10

04/05/2022 - Admission (Discharged) in HCMC Psychiatry 08 - 1 (continued)

Discharge Summary (continued)

Discharge plans and follow-up as outlined. I discussed with the resident and agree with the resident's findings and plan documented in the resident's note from above. Any revisions by me are documented. The discharge process has taken: greater than 30 minutes

Heath, Ian J, MD, 4/21/2022 2:43 PM

Electronically signed by Heath, Ian J, MD at 4/21/2022 2:43 PM